F 000 INITIAL COMMENTS This report is the result of an unannounced Off-Hours Quality indicator Survey conducted at Pressige Care & Rehabilitation on 11/3/13, 11/4/13, 11/5/13, 11/5/13 and 11/7/13. The survey included data collection on 14/3/13 from 7:00 pm to 9:30 pm. A sample of 27 residents was selected from a census of 63. The sample included 22 current residents and the records of 6 former and/or discharged residents. MS Insw ESS The survey was completed by: The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services District 3, Unit B, C & D P. O. Box 458:9 Telephone: 360.684.8429 Fax: 360.684.8429	STATEMENT OF DESIDENCIES AND PLAN OF CORRECTION SOURCE NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - CAMAS (XA) ID SUMMARY STATEMENT OF DEFICIENCIES (REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted at Prestige Care & Rehabilitation on 11/3/13, The survey included data collection on 11/3/13. The survey included 22 current residents and the records of 5 former and/or discharged residents. The survey was completed by: (X3) MULTIPLE CONSTRUCTION A SURDING STREET ADDRESS GITY, STATE, ZIF CODE 740 NE DALLAS TREET CAMAS, WA 9607 PRETIX PRETIX PRETIX CAMAS, WA 9607 PRETIX PRE	SURVEY PLETED 17/2013 (X6) COMPLETION
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are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 156 SS=D	RIGHTS, RULES, S The facility must inf	483.10(b)(1) NOTICE OF SERVICES, CHARGES form the resident both orally anguage that the resident	F	be bea	side give uty	t #32's family member wi a list of charges for the parlor, which are not cover			***************************************
	understands of his regulations governi responsibilities duri facility must also pr	or her rights and all rules and ng resident conduct and ng the stay in the facility. The ovide the resident with the		for	vide m.	icaid. Facility will also an Explanation of Charge	3		ar a systematical association and the second and th
	§1919(e)(6) of the A	State developed under Act. Such notification must be		the	ir pr	n of specific charges, and cing, not covered under a	i		-
	made prior to or up	on admission and during the		Me	dica	d stay will be added to the			
	any amendments to	ceipt of such information, and it, must be acknowledged in		fac	lity	s current admission packet	. :. 2 :		
	writing.	vid umaribe sckillowiedded III		wh	ich i	provided to resident and/	or		
				fan	ily	n or shortly following			
	The facility must infi entitled to Medicaid	orm each resident who is benefits, in writing, at the time			Š	on to the facility.			
	of admission to the	nursing facility or, when the		SSI) and	SSA re-educated on	•		
	resident becomes e	ligible for Medicaid of the		11/2	26/2	13 regarding explanation	of		1
	items and services	that are included in nursing		cha	rges	and providing prices for	÷	***	١
de distribute de la companya de la c	which the resident n	er the State plan and for nay not be charged; those		tho	sc its dica	ms not coevered by	;	-	
	other items and sen	vices that the facility offers						į	
	the amount of charg	sident may be charged, and les for those services; and		To	πon	tor for correction of	v (
į	inform each residen	t when changes are made to		defi	cien	y, admission paperwork		-	l
VALUE AND	the items and service	es specified in paragraphs (5)		che	klis	will be used with	t		
• •	(i)(A) and (B) of this	section.		adm	1531	ns and reviewed at care	į		1
·	The facility must infe			con	eren	ces. Admission paperwork			
	at the time of admis-	orm each resident before, or sion, and periodically during		com	plet	on will be reviewed at			1
***************************************	the resident's stay of	of services available in the		mor	thly	QAPI meetings for three			
F.	facility and of charge	s for those services,		mon	ths	or until resolved to ensure			1
	including any charge	s for services not covered		com	plia	ice.		•	-
	under Medicare or b	y the facility's per diem rate.			io and				
1	•	."				trator will ensure			
	legal rights which inc	nish a written description of bludes:		com	plias	:C e.		11/30/2013.	
	A description of the i	manner of protecting personal			1		į		

PRINTED: 11/19/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFIDIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (XX) MULTIPLE CONSTRUĞTION (X3) DATE SURVEY COMPLETED A. BUILDING _ 505273 B. WING 11/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 740 NE DALLAS STREET PRESTIGE CARE & REHABILITATION - CAMAS CAMAS, WA 98607 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EAC - CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATIONS TAG DEFICIENCY) F 156 Continued From page 2 F 156 funds, under paragraph (c) of this section: A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use

such benefits.

Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENIE	RS FOR MEDICARE	& MEDICAID SERVICES	····				ΔN	IB NO.	0938-039	
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F 156	Continued From pa	ge 3		158			anne i manuschi de apariche			T
	by: Based on observate review, it was deter provide residents/reviewing, a list of services for 1 of 3 of (#32) reviewed for replaced residents/revion for when making find Findings include; Resident #32 was a 105 and had difference of the findings include;	ion, interview and record mined the facility failed to sident's representative, in vices resident would or would and changes to the list of urrent sampled residents esident rights. This failure sident's representatives at risk and of charges and changes to vould or would not be charged ancial decisions. dmitted to the facility on iagnoses including heart zheirner's disease, and								THE PROPERTY OF THE PROPERTY O
The section of the se	resident was highly vision, had long and problems, was seve	ited 09/24/13, indicated the impaired in hearing and short term memory rely impaired with daily lis, and had continuous	ere						•	The state of the s
	resident indicated he list of services and it would not be charge they need some mo	a.m., a family member of the did not remember seeing a sems the resident would and d for. "They let me know if ney, but nothing like that" (a ents would or would not be		The state of the s				endergende i grand en franzo de ende grande grande en en en en encentrat de entre en		

PRINTED: 11/19/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (XX) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 505273 B. WING 11/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP GODE 740 NE DALLAS STREET PRESTIGE CARE & REHABILITATION - CAMAS CAMAS, WA 98607 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PEOVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (X5) COMPLETION PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 156 | Continued From page 4 F 156 On 11/05/13, a list of services and their cost was observed outside the beauty shop. On 11/05/13 at 3:53 p.m., the Social Services Director (SSD) stated the admission packet had a form providing information about what was and was not covered. This form did not provide information of the cost of services. This form was reviewed with residents/resident's representative at the time of admission. The SSD stated there was a list of extra services and their prices posted outside the beauty shop. The SSD indicated the list of services was only posted outside the beauty shop and was not provided to residents/resident's representative other than posted outside the beauty shop. At 4:32 p.m., the Administrator (ADM) stated the facility did not have a list of services they provided residents and resident's representative periodically of the services the resident would or would not have to pay for. The ADM indicated the facility had not provided a list of services to residents and/or resident's representatives when changes were made to the list of services resident's would or would not be charged for.

F 247 | 483, 15(e)(2) RIGHT TO NOTICE BEFORE SS=D ROOM/ROOMMATE CHANGE

> A resident has the right to receive notice before the resident's room or roommate in the facility is changed.

This REQUIREMENT is not met as evidenced

F247

F 247

SSD and SSA were re-educated on 11/6/2013 regarding facility policy, including forms for use in notification of room moves and receiving new roommates.

FORM CMS-2507(02-99) Previous Versions Obsolete

Event ID: HFSP11

Facility ID, WA17603

If continuation sheet Page 5 of 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	FÖF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:]	TIPLE CO		TION	(X3) DATE SURVEY COMPLETED	
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	determined the fact of 20 current samp reviewed for notific This failure placed adjusting to a new diminished quality. Findings include: The facility's policy Change/New Room policy to notify each changes and new remarks and new remarks. The procedure included the procedure included advance. 1) Resident #39 was 05/30/13 with diagratic diabetes and musc Minimum Data Set indicated the reside required extensive of daily living.	w and record review, it was silly failed to provide notice to 2 sied residents (#39 & 88) sation of roommate changes, residents at risk for difficulty roommate and potential of life. "Notification of Room nate" noted, "It is this center's a resident in advance of room	F2	a i i i i i i i i i i i i i i i i i i i	dmist norming Room nonth nonth custom gardin	e room moves and new ions will be discussed in g management meetings. moves will be reviewed e at QAPI for the next three or until resolved. Ongoing rooms/roommates will be.	ach e	11/30/2013
	she had not receive current roommate r resident indicated s	of prior notice before her noved into the room. The he had been in the fireplace orning to her room, she found						
	13 with diagn	s admitted to the facility on oses including rehabilitation, etes and dementia. The	W. ************************************					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES.

AND PLAN OF	(EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1	ST 74	D NE DALL NMAS, WA PÉ	ISS, CITY, STATE, ZIP CODE	11/0	E SURVEY PLETED 07/2013
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PRESTIGI (X4) ID PREFIX	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	74 CA	D NE DALL NMAS, WA PÉ	98607		
PREFIX	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF	IX	Pf			
PREFIX	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF		PF	IOVIDER'S PLAN OF CORRECTION		,
	,		<u> </u>		CROSS	- CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROP DEFIGIENCY)	RF	(X5) COMPLETION DATE
	resident was able to alert and oriented.	ted 09/22/13, indicated the ormake needs known and was	F :	247				
	a roommate moving #88 stated, "No, the On 11/05/13 at 4:16 Director (SSD) state notice if there is go SSD provided a "No form which failed to	p.m., when asked if notice of g in had been given, Resident by just brought the person in." 5 p.m., the Social Services and, "We try to give a 72 houring to be a room change." The offication of Room Change" document Resident #39 had		***************************************				
	someone comes in double room, they l roommate at any tir When asked if Res	Ve don't always notify if on admit. If they are in a know they could get a ne." dent #39 had been given wing a roommate, the SSD		. And the second	and the second control of the second control			
1	stated, "It [a social : talked to her afterw	service chart note] shows we ard to see how it was going on g to the room change form.	•					
f	riotice of receiving a	dent #88 had received prior a roommate, the SSD stated, on that one. We did not tell a roommate,"	·				The state of the s	
SS=D (483.20(d), 483.20(k COMPREHENSIVE	CARE PLANS	F2	79	F279 Resid	onts #88 and #137's care p	lans	- And Antique management of the state of the
t	n tacility must use to to develop, review a comprehensive plar	ne results of the assessment and revise the resident's and care.	•		mana	ppdated regarding pain tement, including non- acological interventions.	Pre-194 1	олд деровин так индериндарда

DEPART	TMENT OF HEALTH	AND HUMAN SERVICES			į	F		D: 11/19/2013 AAPPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-039			
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MUE A. BUILD		E CONSTRU		(X3) DA	TE SURVEY MPLETED	
		505273	B. WING	i			1 11	/07/2013	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	51	REET ADDR	SS, CITY, STATE, ZIP CODE	11	10112013	
PRESTIC	GE CARE & REHABIL	ITATION - CAMAS		ŧ	10 NE DALL AMAS, WA				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF		(EAC	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD FREE RENCED TO THE APPROPRIECTION OF THE APPROPRIECTION O	DRE	(XS) COMPLETION DATE	
F 279	Continued From pa	ige 7	F:	279	Review to ensur	ed like residents' care plan e pain addressed.	15	The second secon	
	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ant that includes measurable stables to meet a resident's and mental and psychosocial stified in the comprehensive		And the second s	11/7/20 pain car the pote	vere re-educated on 3 regarding inclusion of 5 plan for residents who h atial for or actual pain issues ns will be reviewed each	ave ues.		
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	describe the services that are tain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise (483.25 but are not provided is exercise of rights under the right to refuse treatment).			week ati address	IDT to ensure pain is d as appropriate.	i :	11/30/2013.	
The state of the s	by: Based on observat review, it was deten develop a compreh- measurable objection specific intervention management and tr current sampled res for care planning. T	eatment of pain for 2 of 18 sidents (#88 & 137) reviewed his failure placed residents at adequate care and services to		e de delle de la companie de la comp					
	Findings include:	•			- and an analysis of the second secon	,	,	***	
	13 with diagnomean disease, chron	s readmitted to the facility on oses including rehabilitation, pressure ulcer, diabetes, no pain, sleep apnea, sease, muscle weakness and			THE THE THE PROPERTY OF THE PR				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRU	TION			E SURVEY PLETED
		505273	B. WING		State of the state		11/	07/2013
	PROVIDER OR SUPPLIER	ITATION - CAMAS		STREET ADDR 740 NE DALL CAMAS, WA	ă.	COE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EAG	OVIDER'S PLAN OF COI GORRECTIVE ACTION REFERENCED TO THE DEFICIENCY)	I SHOULD	BE	(X5) COMPLETION DATE
F 279	Continued From pa	age 8	F2	79			* de la companya de l	
	assessment tool, d resident was alert a person assist with had limited range of	mum Data Set (MDS), an ated 09/22/13, indicated the and oriented, required two activities of daily living (ADLs), of motion in lower extremities, medication as needed for	The second section of the second section section section sections section sections s		THE REPORT OF THE PARTY OF THE			
		2 p.m., Resident #88 reported are certain exercises that			The state of the s			-
	The Initial Pain Quidocumented the rediscomfort in the pa	estionnaire, dated 09/16/13, sident "had pain and ast week."	· American Charles and Charles		3. 年 (
	09/17/13 for	ocumented an order on "apply to k PRN (as needed) for 12 hrs	A Total Community of the Community of th					,
S. Company of the Laboratory o	Physician Orders of 09/15/13 for Oxyco every 4 hours PRN	ocumented an order on done, 5 to 10 mg (milligrams), for pain.	Deliniary, Transportations.		A compression of the compression			
27 12 12 12 12 12 12 12 12 12 12 12 12 12	Physician Orders d 08/08/13 for for pain and/or feve	ocumented an order on 650 mg, every 4 hours PRN er.	outcompany the property of					
THE PARTY OF THE P	Record review should not address the	wed the resident's care plan resident's pain.						negy dy charge published con-
TO THE PERSON OF	stated she was una plan of the resident will add one now. T	2 p.m., Licensed Nurse (LN) A ble to find pain on the care 's medical chart. LN A said, "I here does need to be one for on he was in when he came			Name of the Party	·.	No. 10.1 In the second	A COLUMN TO THE PART OF THE PA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUC	TION		TE SURVEY APLETED	
	,	505273	5. WING	;			111	07/2013	
	FROVIDER OR SUPPLIER BE CARE & REHABIL	ITATION - CAMAS		7	TREET ADDR 40 NE DALL AMÀS, WA		2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EAC)	DYIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIEMCY)	BE	(X5) COMPLETION DATE	
F 279	information. A Pret	age 9 collity provided additional minary Care Plan, dated the resident would	ŗ.	279					
	"experience desire	d pain relief as evidenced by of evidence of objective signs							
	measurable object specific intervention	are Plan did not provide ves and timetables, with ns/services for the reatment of pain for Resident	The second secon						
THE PARTY OF THE P	13 with diagr kidney disease, mu disease, depressio	vas admitted to the facility on noses including rehabilitation, iscle weakness, Alzheimer's n, anxiety, dementia, heart sease and communication	· · · · · · · · · · · · · · · · · · ·				-		
The second secon	the resident was se experienced disorg extensive assistant	6, dated 10/20/13, indicated everely cognitively impaired, anized thinking, required be with ADLs, and received on for occasional pain.			·			THE PROPERTY OF THE PROPERTY O	
**************************************	The Admission Nur 10/13/13, documen movement."	sing Database, dated ted "joint pain with	Will also a constant of the co		3 2 2	•		174 1979	
	Physician Orders d order for Acetamino PRN for mild pain o	ocumented on 10/13/13 an pophen 650mg every 4 hours or fever.						The state of the s	
	Physician Orders d 10/13/13 for twice a day.	ocumented an order on l, 650mg, to be given routinely				in the second se	empererente de la constanta de		

PRINTED: 11/19/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUKTION (X3) DATE SURVEY A. BUILDING COMPLETED 505273 B, WING 11/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDPESS, CITY, STATE, ZIP CODE 740 NE DALLAS STREET PRESTIGE CARE & REHABILITATION - CAMAS CAMAS WA 98507 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PIPOVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROS: REFERENCED TO THE APPROPRIATE DEFICIENCY) F 279 Continued From page 10 F 279 Record review showed pain was not included on the resident's care plan. On 11/05/13 at 12:57 p.m., LN B stated, "The resident does need to have a care plan for pain. It must have been overlooked, I will put in one right now." On 11/07/13, the facility provided additional information. A Preliminary Care Plan, dated 10/13/13, documented the resident would "experience desired pain relief as evidenced by stating so, or lack of evidence of objective signs of pain (moaning, wincing, etc.)," The Preliminary Care Plan did not provide measurable objectives and timetables with specific interventions/services for management and treatment of pain for Resident #137. F 412 483.55(b) ROUTINE/EMERGENCY DENTAL F 412 SS=D SERVICES IN NFS F412 Dental appointment for resident #45 The nursing facility must provide or obtain from was scheduled and transportation an outside resource, in accordance with arranged for 11/14/2013, POA and §483.75(h) of this part, routine (to the extent SSA dissussed upcoming covered under the State plan); and emergency. appointment and determined it would dental services to meet the needs of each be cancelled secondary to denture resident; must, if necessary, assist the resident in making appointments; and by arranging for type of preference is not covered by transportation to and from the dentist's office; and state plan, and family declines type must promptly refer residents with lost or that would be covered by same plan. damaged dentures to a dentist. Resident has stable weights, consume a diet of regular texture

by:

This REQUIREMENT is not met as evidenced

and has to complications or pain

related to dental issues.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A BUILE		E CONSTRU	CTION	(X3) DA	7. 0338-039 T TE SURVEY MPLETED
		505273	B. WING	È			4	1/07/2013
	PROVIDER OR SUPPLIER			7		ESS, CITY, STATE, ZIP COD AS STREET 98607	PE .	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		: (EAW	OVIDER'S PLAN OF CORRI H CORRECTIVE ACTION SH REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 412	review, it was dete provide dental senteresidents (#45) revidents (#45) revidents (#45) revidents, potential quality of life. Findings include: Resident #45 was 12 with diagrates despend tool, it moderately cognitive extensive assistant living. On 11/04/13 at 12:10 observed to have in The resident stated dentures. On 11/05/13 at 11:10 C stated if a reside services, nursing we schedule a dental a residents could be residents could be residents could be residents.	age 11 Ition, interview and record rmined the facility failed to rices for 1 of 3 current sampled fiewed for dental services. This esident at risk for chewing I weight loss and a diminished readmitted to the facility on noses including dementia and ident's Minimum Data Set, an idicated the resident was rely impaired and required be with most activities of daily 51 p.m., Resident #45 was multiple missing upper teeth. I she could not afford 69 a.m., Licensed Nurse (LN) int was in need of dental ould inform Social Services to appointment. When asked how assessed for and receive red, "If the family can't afford	F	412	interval requires and sati continus on any Dental weekly in mont until re	d SSD will ensure	nts as ervice also low up arise. ewed at lowed	11/30/2013
	Assistant (SSA) pro Department of Soci declined to cover a Resident #45 in 201 alternate type of de for Resident #45, Ti	ow." i p.m., the Social Services wided documentation the all and Health Services particular type of denture for 1. The SSA confirmed an inture had not been requested the SSA stated, "We have not at this time" and nothing had			All Control of the Co			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) FROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER-	A. SUILE		LE CONSTRUC	TIÓN		TE SURVEY MPLETED
		505273	B. WING				44	/07/2013
	PROVIDER OR SUPPLIEF			1	STREET ADDR 40 NE DALL CAMAS, WA			Minus (d
(X4) ID PREFIX TAQ	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EAC)	OVIDER'S PLAN OF CORRECTION (XS) I CORRECTIVE ACTION SHOULD BE COMPLET REPERENCED TO THE APPROPRIATE DATE DEFICIENCY)		
F 412	been done since 2 obtaining dentures The SSA stated shaccepts Medicaid and would work or the resident. At 3:01 p.m., Resiget dentures withousked if there was resident want dentures to the control of	011 to assist Resident #45 in	F 2	11 2			-	
	37(12-94) Previous Vassions		•					